The Werc Shop, Inc.
2585 Nina Street
Pasadena, CA 91107
www.TheWercShop.com
310-703-9567

Jeffrey C. Raber, Ph.D., President

December 3, 2013

Rep. Kevin Cotter, Chair
House Judiciary Committee
House Office Building
Lansing, MI 48090

Re: Written testimony regarding the Distribution of Medical Marihuana in Michigan

Rep. Cotter and Members of the Judiciary Committee:

I would first like to commend you on seeking to establish a good foundation and framework upon which a robust and healthy medical cannabis distribution program can operate. However, there are some critical elements pertaining to protecting patient health and safety, particularly product quality control and assurance standards, that are necessary to be included if you are to develop a successful and safe medical program.

As a brief introduction we are an independent analytical laboratory that has offered medical cannabis analysis in California for the last 3 years. As professional scientists with formal chemistry degrees we are recognized by many as scientific leaders and are respected for our depth of knowledge and innovative analysis efforts with cannabis. Our comprehensive cannabis testing program covers over 45 different cannabinoids and terpenes, detection of 30 different pesticides and hundreds of microbiological contaminants. We have processed thousands of samples in California and benefit from vast cannabis and botanical analytical expertise retained by professional scientists, one of whom is Dutch and had previously worked within the quality control department of the Dutch national medical cannabis distribution program that places pharmaceutical grade cannabis inside of pharmacies. I can assure you we are more than capable of doing all of the independent testing your program would require to provide medicine to your patient population.

1.) **Cannabis is a botanical product and can be analyzed and scrutinized the same as any other product of botanical origin.** The cannabis plant in the form of hemp is handled as a dietary supplement by operators in over 30 other countries, essentially performing cannabinoid quantification and the same safety screening as is required for any other dietary product consumed today. There are well established guidelines and methods for analysis at a variety of purity levels available for scientists to understand and use in guiding their analysis efforts accordingly. Essentially, well known tires can be put on this new vehicle without having to re-invent the wheel.

2.) **Testing and safety screening of medical cannabis is successfully done today in a number of different locations around the world.** In the Netherlands they have been testing and assuring medical cannabis for their national medical program which provides registered products via prescription to patients in a pharmacy. Canada has always required laboratory testing and safety screening of their medical cannabis and will continue to do so in their new program beginning later this year. Israel ensures all of their medical marijuana is adequately tested as well. Analytical methods, operating guidelines and regulatory structures for these efforts have been clearly established in other states in American and can easily be adopted by Michigan to effectively regulate the laboratory operations and the distribution supply chain quality.

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3.) **Safety screening and quality control regulations need to exist for medical cannabis.** Throughout our work we've been able to confirm 25% of random samples selected in Los Angeles have unsafe levels of microbiological contamination, 15% of samples have pesticides or plant growth regulators present and edible products are gravely mislabeled with un-identified dosages. Perhaps most concerning when considering this is that we have recently confirmed almost 70% of a chemical residue present on a dried cannabis flower product can be inhaled by a patient consuming through inhalation (reference attached). What we observe is very alarming and I believe proper patient protections that address labeling and safety standards are absolutely required at the state level so that sick, immunocompromised and chemotherapy weakened patients can seek to utilize cannabis for relief without concerns of further jeopardizing their health due to contaminants in their medicine.

4.) **Laboratory testing needs to be performed by an independent organization.** Independent laboratory relationships assure integrity of reporting and allow for easier regulatory monitoring of the entire program. Proper scientific testing of medical cannabis is best provided by professional scientists with formal educations and strong backgrounds in the sciences to possess a thorough understanding of the analytical tools utilized in this work. Medicinal analysis requires expensive infrastructure elements, very technical skill sets and relevant know-how to perform properly. Allowing just anyone to provide this function would in no way be in the best interest of patient consumers. Better efficiencies and economies of scale can far more easily be achieved by independent third-party laboratories who would also further offer an unbiased reporting perspective. The analytical equipment required to provide all of the tests for a Dispensary could easily exceed $500,000 and additionally would require further specialized laboratory infrastructure and advanced degreed individuals to calibrate, operate and maintain. This is a unique and specialized area of expertise that should not be expected to be mastered by just anyone. It is also one that requires incredible attention to detail and accuracy; it needs to be done at professional levels.

Independently-verified labels provided by third-party laboratories offer the best method of ensuring patient safety. Labeling offers detailed product information being made available to those who need to find the right medicine for their individual ailments and needs. It would be a great disservice to your state's patients if you do not include at least some level of independent testing and accurate labeling requirements on all of the medicinal products produced. Please consider the importance of product safety and consumer protection when creating your distribution system. I would be more than happy to clarify or further discuss any of these points if that would be helpful to you in establishing adequate safety standards for cannabis.

Cannabaceutical™ Facts

Δ⁹-THC Max:	**16.27 %**	**Sour Diesel**		Sativa	
Δ⁹-THCA	18.11 %				
Δ⁹-THC	0.38 %	**Tested On:**	02/01/13		
CBD Max:	**0.30 %**	Limonene	7.3	mg/g	
CBDA	0.27 %	Myrcene	4.0	mg/g	Tested by The Werc Shop™
CBD	0.07 %	β-Caryophyllene	2.4	mg/g	
CBG Max:	**0.47 %**	Germacrene B	2.4	mg/g	
Pesticides Screen	PASS	Microbiological Screen		GOLD	

Keep Out of Reach of Children. Do Not Operate Heavy Machinery While Medicated. For Medical Use Only. CA Health & Safety Code 1362.5

Sincerely,

Jeffrey C. Raber, Ph.D.
President
The Werc Shop, Inc.
jeff@TheWercShop.com

TESTIMONY BEFORE THE

MICHIGAN HOUSE JUDICIARY COMMITTEE

Urging Support for HB 5104

Giving End-of-Life Patients the Option to Not Smoke

+

a proposed amendment to give them direct access to Medical Marijuana

by

Cathleen Graham, RN, CHPN *(Certified Hospice and Palliative Nurse)*

December 5, 2013

Good morning. I am Cathleen Graham and I am a Certified Hospice and Palliative Care Registered Nurse. For the past 5 years, I have worked for one of the largest hospice programs in the nation caring for patients, usually in their own homes, throughout the western part of our state – from Grand Rapids to Traverse City.

When cure is no longer possible, hospice offers services focused on pain relief, comfort and enhancing quality-of-life.

I have been directly involved with the care of dozens of Michigan patients whose end-of-life journey was significantly helped by medical marihuana.

From my personal experience with patients facing their final days, I have seen medical marihuana accomplish many things, including:

- control nausea of a patient undergoing chemotherapy
- stimulate appetite in a patient facing malnutrition
- ease muscle spasms
- decrease pain
- improve ability to sleep

You may be surprised, but during this time, I have had <u>only one patient who smoked</u> marihuana. They rest took medical cannabis in different ways:

- Liquids/Gels/Lotions
- Drops under the tongue
- A wide variety of Edibles – from cake to pizza

- Smoothies and other Drinks
- Capsules
- Vaporizers and
- Some made it into Tea.

You can imagine how upset these families were when they heard about the Michigan Court of Appeals ruling in September that said smoking was virtually the only legal way for using this medicine.

I am testifying today to offer my strongest possible support for **HB 5104**. It would broaden the definition of usable marihuana so that non-smoking forms of this legal medicine can be available in Michigan.

Many patients we care for are proud that they have never smoked during their lifetimes. Now we must tell them the law says they have to start smoking to get the relief from their pain, nausea, tremors and other symptoms that cannabis provides.

Furthermore, many hospice patients live in assisted living facilities, nursing homes and hospice residences – places where all smoking is prohibited. Until the legislature passes HB 5104, they are effectively prohibited from taking this medicine that is available for all others.

For every one hospice patient who takes cannabis for symptom relief, I would estimate that there are 20 who could benefit from it – but don't. Numerous obstacles are causing this. Much of it relates to not having access to regulated dispensaries or provisioning centers. There is also a lack of up-to-date, objective, fact-based education for health care professionals about the uses of cannabis.

In addition, there is one obstacle specific to end-of-life patients. And this Committee has the opportunity to make a difference. Since House Bill 5104, seems to be headed through the entire legislative processing - and it amends the MMMA, I would like to take this opportunity to propose this bill be a vehicle to also correct an oversight that will help thousands of qualified patients who are at the end of their lives.

As you may recall, hospice was mentioned frequently during the 2008 campaign to legalize and regulate Medical Marijuana. Our patients were singled out as examples those who could really take advantage of cannabis, if it was legal.

Unfortunately, the definition of "Debilitating medical condition" and the patient-sign-up process of MMMA, effectively prevent many end-of-life patients from taking advantage of this worthwhile medicine.

Let me illustrate. I cannot adequately describe to you the difficult situation hospice team members face when we first meet with a patient and family that has just been given a life expectancy of six months or less.

Part of our responsibility is to normalize the dying process and educate on what the next few months may be like. We must be honest and explain there is the likelihood of developing some extremely unpleasant symptoms. Studies have shown that nausea

(usually with vomiting) occurs with 70% of terminally ill patients. The natural dying process isn't petty.

We can mention that for some, those symptoms are relieved by medical marihuana. However, they would have to wait until they clearly develop one of the specific conditions listed in the law – then find a doctor to certify them as a patient, then apply and wait another 4 to 6 weeks to receive a MMMP card to obtain it. Finally, when it arrives, the patient or caregiver - WILL HAVE TO GROW IT!

Precious days (sometimes weeks and months) are spent qualifying someone for a Michigan Medical Marihuana Program card – even for these patients who have already been legally qualified as having a terminal illness. That is wrong and not what the voters intended.

In Michigan, if a patient has been medically determined to be eligible for end-of-life care, certainly they should be able to take advantage of the relief brought by medical cannabis. Can anyone give a good reason why I can provide a terminally ill patient with Oxycodone, Fentanyl, Dilaudid, Hydrocodone, Methadone, even Morphine – much easier than cannabis?

This situation can be alleviated by a simple amendment to SB 5104 that adds to the list of qualifying conditions:

"ADMISSION INTO A HOSPICE CARE PROGRAM LICENSED BY MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS, BUREAU OF HEALTH CARE SERVICES".

A doctor would still have to meet with the patient and discuss the pros and cons of the medical marijuana option, but the time this all takes would be much shorter. With our patients, quality time with reduced symptoms is the most important thing there is. You can give them more of that time by adding this amendment.

Hospice recognizes providing a peaceful and comfortable death is an essential goal of health care. Death is not a failure, but rather living and dying with dignity, on your own terms, is an ultimate success. With this one legislative change, thousands more of our friends, neighbors and families will be able to find this success.

I urge you to consider adding this amendment - then quickly report HB 5104 to the full House for its consideration.

Cathleen Graham, RN, CHPN is a Certified Hospice and Palliative Nurse and a member of the American Holistic Nurses Association and the American Society for Pain Management Nursing

She can be reached at *cathleen@cannanurse.com*

TESTIMONY BEFORE THE

MICHIGAN HOUSE JUDICIARY COMMITTEE

Report Card for HB 4271 & SB 660:

Both FAIL in Protecting Michigan Patients

by

Cathleen Graham, RN, CHPN *(Certified Hospice and Palliative Nurse)*

December 5, 2013

Good morning. I am Cathleen Graham and I am a Certified Hospice and Palliative Care Registered Nurse. For the past 5 years, I have worked for one of the largest hospice programs in the nation caring for patients in the western part of our state – from Grand Rapids to Traverse City.

I had the opportunity to testify before this committee last May. At that time, I was here in support of Rep. Mike Callton's bill, HB 4271, that creates a local-option, medical marihuana "provisioning system." I believed the passage of his bill would mean thousands of Michigan residents at the end-of-life would finally be able to purchase a medicine their doctor and hospice team recommends.

Since then, I have also studied SB 660 and its plan to make pharmaceutical-grade cannabis available to qualified patients who choose it.

There is much I like about both bills.

Unfortunately, there is also much about both bills that is seriously lacking.

When I was here before, I suggested this committee add amendments that would help protect patients. I did that because I believe that lawful marihuana users should have the same kind of confidence in knowing what is in their product as they do with other medications and herbal remedies.

There is a major problem we health care providers have in working with patients who choose to use marihuana: that is, the lack of basic label information required for all other medications (prescription, non-prescription and botanical).

HB 4271, as introduced, had very few protections for patients. I am pleased that in the most recent version I have seen (DRAFT 4) some improvements have been made.

SB 660 definitely has more requirements for safety testing and for the disclosure of active ingredients. Yet, it has other flaws that really concern me.

I found it difficult to compare these two approaches. With the assistance of the Cannabis Standards Institute, I put together the chart you will find attached to my written testimony. I wanted to see how each bill addresses the issues medical professionals feel are important.

To get an even broader view, we also included the legislation and regulations adopted this year in other states.

I think you will find this simple, one-page report thought-provoking – I found it extremely disappointing. EVERY OTHER STATE that passed new regulations this year did far more to protect their residents than either of the two bills you are considering today.

I never expected all of my suggestions would be added – but of the 13 specific recommendations I made in my testimony – none are included in Rep. Callton's bill – however, most are included in the other four states.

Of these two bill before you, the Senate Bill, theoretically would do the most – but since it would only take effect after the federal government takes action – it certainly isn't likely to help the 50,000 end-of-life patients in Michigan soon enough – if ever.

The House bill is much more realistic – but it ignores the basic right to information patients deserve. Accurate and useful labels are needed to help guide both medical teams and patients in making informed choices because it will allow for a specific dosage to be prescribed, like with all other medications.

Botanical medicine, such as cannabis, works better if it is used as part of an overall health care plan. These labels will aid medical professionals in the ability to provide a holistic approach to patient-centered care. It will help address consistency across multiple product types.

I urge you to stop – to not report either of these bills -- until the needs of patients are addressed. Neither one meets FDA standards for producing pharmaceutical grade products. Neither one meets FDA standards for producing food grade products. Shockingly, neither one even meets the standards for producing animal feed.

Finally, I don't think you need to choose between the two bills – the provisioning centers of HB 4271 could be added to the growing and processing regulations of SB 660 – **along with a healthy dose of patient safety protections** --and the result would be good for all concerned.

Cathleen Graham, RN, CHPN is a Certified Hospice and Palliative Nurse and a member of the American Holistic Nurses Association and the American Society for Pain Management Nursing

She can be reached at *cathleen@cannanurse.com*

Report Card for HB 4271 and SB 660

Patient Safety Requirement	HB 4271	SB 660	Colo	Wash	Conn	Mass
Compliance with requirements for similar products not containing marihuana			✓	✓	✓	✓
Compliance with state food Laws			✓	✓	✓	✓
Every harvest batch tested			✓	✓	✓	✓
Harvest held in quarantine until the lab results reported			✓	✓	✓	
Label gives batch number or bar code to facilitate recalls			✓	✓	✓	✓
Label gives date of dispensing		✓	✓		✓	✓
Label gives date when marijuana product was made		N/A	✓	✓	✓	✓
Label gives name and/or license number of cultivation facility where grown		✓	✓	✓	✓	✓
Label gives name and/or license number of facility where product produced		N/A	✓	✓	✓	✓
Label gives net weight	✓	✓	✓	✓	✓	✓
Label gives product expiration date			✓		✓	✓
Label gives quantity of cannabidiol (CBD)		✓	✓	✓	✓	
Label gives quantity of cannabidiol acid (CBDA)		✓	✓		✓	
Label gives quantity of delta 9-tetrahydrocannabinol (THC)		✓	✓	✓	✓	✓
Label gives quantity of delta 9-tetrahydrocannabinol acid (THCA)		✓	✓	✓	✓	
Label gives retail center name, license number, address & phone		✓	✓	✓	✓	✓
Label lists of all nonorganic pesticides, fungicides, herbicides used during cultivation			✓	✓	N/A	N/A
Label lists of all solvents and chemicals used in the creation of a concentrate			✓	✓		
Label printed on or securely attached to any package containing marihuana		✓	✓	✓	✓	✓
Label printed on or securely attached to any package containing marihuana products	✓	N/A	✓	✓	✓	✓
Label provides warning that product contains marijuana	✓		✓	✓	✓	✓
Marihuana dispensed in child-resistant container			✓		✓	✓
Marihuana dispensed in sealed, tamper-evident container			✓	✓	✓	✓
Marihuana products dispensed in child-resistant container		N/A	✓	✓	✓	✓
Marihuana products dispensed in sealed, tamper-evident container		N/A	✓	✓	✓	✓
Name of patient on label	✓				✓	
Packaging, labeling & testing requirements for wholesale			✓	✓	✓	✓
Pass/Fail rating based on a chemical residue analysis	P	✓	✓	✓	✓	✓
Pass/Fail rating based on a microbiological analysis	P	✓	✓	✓	✓	✓
Processed, packaged & labeled according to FDA regs for nutritional supplements					✓	✓
Shall not be labeled “organic” unless certified following state Organic Products rules				✓	✓	✓
Testing be completed immediately prior to final packaging				✓	✓	
Testing by an independent, third-party laboratory	P		✓	✓	✓	✓

Testimony of the **Cannabis Standards Institute**

HB 5104 - There is no mystery about how to measure the active ingredients of cannabis products

House Judiciary Committee, Lansing
8:15 a.m., December 5, 2013

Good Morning, I am Richard Fitzpatrick and I am the President of the *Cannabis Standards Institute (CSI)*. We were formed on the belief that where medical cannabis is legal and regulated; patients deserve access to pharmaceutical quality medicine that is labeled with accurate, useful and independently-verified information.

We compliment the Chair of this Committee on the ambitious inclusion all three bills on today's agenda. Each one of them has the potential to expand access to cannabis products of high quality and safety that meet a patient's unique medical needs. We are submitting separate testimony on the two bills concerning the production and distribution of medical cannabis

First, **HB 5104**. This is the simplest, should be the least controversial; and is the most essential.

No rationale exists for the extremely narrow definition of "useable marijuana" used in the *People v. Carruthers* case. To maximize the benefits and minimize the side effects of cannabis medicine, many qualified patients need to use extracts from marijuana rather than just raw plant material.

We do agree that the cannabis content of these products should be quantified so a determination can be made whether or not a patient has a legally permissible quantity.

In a very revealing comment, the Court of Appeals decision observed "The evidence reflects that the amount of THC contained in an edible cannot be measured, <u>at least not with the testing methods commonly used in police laboratories</u>."

Why should public policy be dependent on "the methods commonly used in police labs?"

The reality is, modern testing technology <u>can</u> provide reports and labels that show just how much THC and other ingredients are in each serving. This process is not uncommon.

For example, Colorado requires edible cannabis products to have labels that report the milligrams of active THC in a standardized serving and how many servings a container includes. The data for this comes from third party, independent labs who have no problem applying scientific methods that result in credible quantification.

In the State of Washington, marijuana dosage and transaction limitations are as follows:

"(1) Single serving. A single serving of a marijuana-infused product amounts to ten milligrams active tetrahydrocannabinol (THC), or Delta 9.
"(2) Maximum number of servings. The maximum number of servings in any one single unit of marijuana-infused product meant to be eaten or swallowed is ten servings or one hundred milligrams of active THC, or Delta 9. A single unit of marijuana-infused extract for inhalation cannot exceed one gram.
"(3) Transaction limitation. A single transaction is limited to one ounce of usable marijuana, sixteen ounces of marijuana-infused product in solid form, seven grams of marijuana-infused extract for inhalation, and seventy-two ounces of marijuana-infused product in liquid form for persons twenty-one years of age and older."

Washington requires this data for come from third party, independent labs.

There is no mystery about how to measure the active ingredients of cannabis products - except, apparently, in some police labs. The easiest way to resolve their problem would be for Michigan law enforcement to issue a *Request for Proposals* (*RFP*) and contract with one or more independent laboratories to do this testing for them.

Meanwhile, it is important to pass HB 5104 and reestablish the many beneficial options for delivering the active ingredients in marijuana to patients who are unwilling or unable to smoke.

Taking this thought one-step further, if this Committee decides to also report-out **SB 660**, please notice that on page 17 of the Senate-passed Substitute Bill, the definition of "Medical Use" would need to be amended using the language from HB 5104 so that users of Pharmaceutical Grade Marijuana will also have the option to not smoke.

As a side note, since House Bill 5104, seems to be headed through the entire legislative process - and since it amends the MMMA - this creates an excellent opportunity to use it as a vehicle to correct an oversight that will make legal, regulated cannabis more easily available to those at the end of life.

A simple amendment to SB 5104 would amend the definition of "Debilitating medical condition" on Page 2. Sec 3 (b)(1) - beginning on line 16 after "nail patella," add:

ADMISSION INTO A HOSPICE CARE PROGRAM LICENSED BY MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS, BUREAU OF HEALTH CARE SERVICES,

The overwhelming majority of people in Michigan favor allowing the legally regulated use of cannabis for terminally ill patients. The passing HB 5104 - with this amendment - will greatly increase access for those who chose this alternative.

Testimony of the **Cannabis Standards Institute**

by Hon. Richard Fitzpatrick

Enhancing the Distribution of Medical Marihuana in Michigan

House Judiciary Committee, Lansing
8:15 a.m., December 5, 2013

Good Morning, I am Richard Fitzpatrick and I am the President of the *Cannabis Standards Institute (CSI)*. We were formed on the belief that where medical cannabis is legal and regulated; patients deserve access to pharmaceutical quality medicine that is labeled with accurate, useful and independently-verified information.

On a personal note, I have the highest respect for this Committee having had the honor of being a member during one of the four terms I served in the Michigan House of Representatives. I regret I cannot be there today to deliver our perspective in person. Should the Committee continue to examine one or more of these bills next week (or at some other time in the future) I will be available in Lansing to discuss the concepts I am about to present in detail and to attend the Committee's meeting.

We compliment the Chair of this Committee on the ambitious inclusion all three bills on today's agenda. Each one of them has the potential to expand access to cannabis products of high quality and safety that meet a patient's unique medical needs. We are submitting separate testimony on HB 5104 that will reestablish the many beneficial options for delivering the active ingredients in marijuana to patients who are unwilling or unable to smoke.

Both of the two bills the committee is reviewing concerning the production and distribution of medical cannabis hold real potential for helping finally resolve the challenge of making medical marijuana more easily available to qualified patients in an appropriate regulated manner.

This is, essentially, a Health Policy issue with two different concerns and one bill focusing on each.

SB 660 would establish a highly professional approach to the production and processing of medical cannabis. That is definitely needed.

Of the 90 tons of cannabis sold legally as medicine in the US last year, a generous estimate would be that four percent (4%) of it had been tested by any sort of scientific methods for purity, safety or labeling of content. Moreover, less than one-quarter of one percent (0.25%) of it was grown, processed and labeled in a manner consistent with FDA requirements for dietary herbal products.

While it may seem self-evident that lawful medical marijuana patients should have the same kind of confidence in knowing what is in their product as they do with other medicines and botanical products, that absolutely is not the situation in the US. For example, in California, an analytical lab consistently detects unsafe levels of pesticides, microbiological contaminants and/or bacteria and mold in more than 25% of the medical cannabis tested.

Just yesterday, (12/4/13) researchers at the University of New Haven in Connecticut discussed a study they are doing on medical cannabis. They reported mold, mildew, insect parts, salmonella and E.Coli are just a handful of substances that can often be found in privately-grown marijuana.

An approach like the one of SB 660 would go a long way to changing that. With dozens - perhaps hundreds - of companies getting licenses to grow and process medical cannabis under strict rules, the free enterprise system - would serve the patients of Michigan well.

The problem is, SB 660 does not include a realistic distribution system. Rescheduling of Cannabis is something that is not be likely to get through the extensive process of being announced, analyzed, approved by congress and implemented in less than 3 - 5 years of when it was initiated.

Even then, transferring marijuana to Schedule II would not automatically authorize its legal distribution. It would do nothing to change the fact that it could still not be prescribed--the FDA would first have to approve a specific product.

Part of the confusion over the actual significance of Schedule II status stems from a misunderstanding of the interrelated, but distinct, functions of the CSA and the Food, Drug, and Cosmetic Act (FDCA). Under the FDCA, the FDA approves specific medical products produced by particular "innovator" (for branded products) or generic manufacturers. For example, oxycodone, an opioid, is in Schedule II. Specific products, such as OxyContin® (an extended-release form), are also in Schedule II. Physicians prescribe a specific branded or generic product, in a particular dose and dosage form.

So, until the FDA approves a smoked marijuana product, it cannot be prescribed or sold in pharmacies for medical use. And the FDA has been clear that smoked marijuana does not pass its rigorous approval standards. At the best, it might be able to be sold by one of the two dozen licensed "compound pharmacies" in Michigan. { MI Board of Pharmacy Regulations R 338.493a.}

Why make Michigan qualified patients wait in pain and discomfort?

There is another option that is immediately available. And here is where Rep. Callton's HB 4271 comes in. Michigan could follow the lead of Connecticut's medical marijuana law that includes pharmacists. The law that the State of Connecticut passed in 2012 legalizing medical marijuana contains strict guidelines, including the requirement that the dispensaries be owned or run by licensed pharmacists.

Their new law allows only state-registered patients or their caregivers to obtain marijuana from dispensaries, which would acquire marijuana from licensed producers. Notably, dispensaries must be run or owned by pharmacists, who would input marijuana data into the state's Prescription Monitoring Program.

The resulting regulations will be stricter than those of other states, such as California and Colorado, which have had medical marijuana laws in place for a few years.

"We are the first state to require having a licensed pharmacist on staff. The law has been crafted well, to ensure that it is going to be handled as close to any other controlled substance that we handle," said Margherita Giuliano, RPh, executive vice president of the Connecticut Pharmacists Association (CPA).

"We don't want Connecticut to follow the path pursued by some other states, which essentially would legalize marijuana for anyone willing to find the right doctor and get the right prescription. Under this proposal . . . the Department of Consumer Protection will be able to carefully regulate and monitor the medicinal use of this drug," Connecticut Governor Dannel P. Malloy said in a statement.

What we are suggesting is folding the provisioning centers of HB 4271 into SB 660. They could be used for distribution until Rescheduling occurs and cannabis can be sold in pharmacies.

It is a challenge for any single entity to excel in three very different fields at the same time. The skills, equipment, personnel, facility and operational style of a cultivation enterprise are very unlike from those required by a product processing facility - and both differ dramatically from the skills, equipment, personnel, facility and operational style needed to operate a retail medical patient center. Recognizing that, these three types of Medical Marijuana Provisioning Centers should be created and licensed:

- "Medical Marihuana Provisioning Cultivation Center" means an entity licensed for the manufacture, planting, preparation, cultivation, growing and harvesting of Medical Marihuana for sale to Medical Marihuana Provisioning Product Centers and to Medical Marihuana Provisioning Patient Centers but not to consumers.

- "Medical Marihuana Provisioning Processing Center" means an entity licensed to process, prepare, label and package for sale to Medical Marihuana Provisioning Patient Centers products infused with Medical Marijuana that are intended for use or consumption other than by smoking, including but not limited to edible and drinkable products, ointments, oils, capsules and tinctures.

- "Medical Marihuana Provisioning Patient Center" means an entity licensed to operate a business that sells Medical Marijuana to registered patients or primary caregivers as defined in (Michigan MMJ definition) but is not a primary caregiver.

At the same time, Michigan's fabulous network of caregivers could continue to provide cannabis for those who qualify and prefer that more personal approach. In addition, some patients will want the control of growing their own.

If you provide an overlay of effective Patient Safety Regulations, the marriage of SB 660 and HB 4271 can be an ideal match to finally deliver what the voters have been expecting since 2008.

We stand ready to assist in any way to help craft a plan that would do just this.